Medi-Cal 101 Webinars – Question & Answers

Wednesday, December 4, 2024
Tuesday, December 10, 2024

Disclaimer: The responses provided by Jane Ogle are informed by her extensive professional and personal experience, including her tenure as the former Deputy Director for Healthcare Delivery Systems at the California Department of Health Care Services and as the former Chief Operating Officer at the Santa Clara Family Health Plan. It is recommended that all information and resource links be verified for accuracy.

Medi-Cal

1. **How long does it take to enroll in Medi-Cal if someone loses private pay insurance?** An eligible person can enroll in Medi-Cal at any time during the year.
2. **Can the patient in Medi-Cal choose their provider, or do they get assigned a provider?** A person can always choose their provider. If they don't make a choice, they will be automatically assigned. You can change your provider at any time. However, the process may take more or less time depending on the plan and the volume of business. Within certain plans, providers may limit the number of members they can accept. If this happens, the patient may need to choose another provider. For example, with Kaiser, you must have had a prior relationship with them to enroll.

3. **Do children with rare diseases automatically get covered by Medi-Cal?** Children with rare diseases are often covered by Medi-Cal because they are considered a family unit and typically have no income, qualifying them for Medi-Cal. There are children from wealthy households who qualify for Medi-Cal due to severe disabilities, and their parents can access California Children's Services (CCS). In these cases, the parents' income is not counted. For CCS eligibility, the family income limit is $40,000. Even if a family exceeds this income threshold, they may still qualify because the child is treated as a separate entity.

Medicare Part A, B, C, D

1. **Why still have Parts A, B, and D if it's all Part C?** It's a matter of timing. Parts A and B were introduced in 1965, and Part D came later, during the 1970s under President Nixon. Part C, developed after Part D, started as the Medicare + Choice option.

2. **Is a person automatically enrolled in Part A? Can someone be automatically enrolled in Part A but not in B or other parts?** Part A is automatic if you've worked 40 quarters. If you look at your paycheck, you'll see a FICA line, which includes a portion for Medicare (23% or 23.5%), matched by your employer. This funds both Part A and Part B. If you become eligible due to disability and have been certified by Social Security for two years, you will automatically become eligible for Medicare. For those under 65, you must be disabled for two years before qualifying for Medicare. At age 65, you are automatically enrolled in Medicare. If you continue working after age 65 and still have employer-provided health insurance, Medicare acts as secondary insurance. Once you retire and lose employer coverage, you become eligible for Part B and Part D. It's important to sign up for Medicare immediately because waiting can result in higher monthly premiums. Additionally, Parts B and D have premiums that can be deducted from your Social Security payments.

   For dual-eligible individuals, premiums for Part B and Part D are covered by the state, allowing individuals to receive Medicare benefits. The cost of Part B and Part D increases for each year you delay enrollment. The exact premium for Part D depends on the benefit package and plan you choose. A recent state decision allows individuals to buy into Part B without qualifying for Part A. They must be on Medi-Cal for Part A. This is a cost-control decision, transferring healthcare management to Medicare.

3. **Why are Medicare deductions shown on pay stubs if you don't use Medicare and only have Medi-Cal?** Everyone pays into Medicare through their paychecks. Medicare is funded by contributions to the trust fund over a person's working life. Medi-Cal, on the other hand, is funded by federal and state tax dollars.

4. **If you don't have 40 work quarters and only have SSI, are you eligible for Medicare Part A?** Individuals on SSI are generally eligible for Medi-Cal. With the recent state decision to buy into Medicare, a person on SSI will now receive both Medicare Part A and Part B.

5. **Is the distinction between Parts A/B/D and Medicare Advantage that A/B/D is fee-for-service (PPO), while Medicare Advantage is managed care (HMO)?** Yes, Medicare Advantage (Part C) operates as an HMO, governed by CMS, with a specific network of providers. If you select an MA plan, you must use providers within that network. Fee-for-service Medicare allows you to see any provider enrolled in Medicare but lacks the protections that an MA plan offers, such as timely access and quality assurance.

Medi-Cal vs. Medicare

1. **Why would someone over the age of 65 be on Medi-Cal instead of Medicare?** There are several reasons: a. They did not work 40 quarters, or they were not married to someone who worked 40 quarters, b. They are undocumented.

   If they are disabled, they can generally qualify for Medicare through their disability, without needing to work the 40 quarters. People who are disabled and on Medi-Cal for 2 years may qualify for Medicare due to their disability, with Medicare becoming the primary payer. Medi-Cal is always the payer of last resort. It is in the state's best interest to get people onto Medicare, as the cost of the medical portion of care will be covered by Medicare, while the state remains responsible for coinsurance, deductibles, and co-pays.

2. **What part of Medicare should a retired state employee enroll in?** CalPERS offers a variety of Medicare options, including Medicare Advantage (MA) plans, PPOs, and Medi-Gap plans. It is important to consult with an expert in this field before retiring to determine which plan best suits individual circumstances.

3. **What have been some consistent challenges for the Medi-Cal and/or Medicare systems over the years?**
   Medi-Cal challenges: The system has been transitioning towards providing more social care, and the state is still learning how to effectively manage this shift. The primary challenge has been serving populations that have previously not been part of the system's focus, such as unhoused individuals and those in facilities for the intellectually disabled. These groups are now part of Medi-Cal's membership, and plans must figure out how to care for and manage the costs associated with them.

   The population health movement initiated by the state is putting pressure on plans to focus on and adequately serve these populations.

Medicare challenges: An aging population and the increasing pressure on the Medicare trust fund are significant concerns. Current estimates suggest that the trust fund may run out of funds sometime in the 2030s or 2040s.

4. **If an individual is on Medi-Cal and turns 65, does their Medi-Cal turn into Medicare, with Medi-Cal being secondary?** When an individual turns 65, they qualify for Medicare and will automatically receive Part A. Medicare will cover hospitalization costs. Part A covers hospital care, Part B covers doctors and outpatient care, Part D covers prescription drugs, and Part C covers Medicare Advantage plans (Medicare HMO options). The key components are Part A, Part B, and Part D. Part A is automatic when you turn 65. Part B requires an application. If you are dual eligible, the state will cover the premium costs for Part B, as it is more advantageous for the state to have you enrolled in Part B to cover physician services under Medicare, rather than under Medi-Cal. The same applies to Part D.

Duals

1. **Can you provide an example of someone dually eligible for Medi-Cal and Medicare?** Any low-income senior or person with disabilities who meets the other eligibility requirements for Medicare would qualify as dually eligible for both Medi-Cal and Medicare.
2. **If a person has a Medi-Cal Advantage plan, can they apply for Cal-MediConnect? How does someone request Cal-MediConnect?** Cal-MediConnect no longer exists; however, each participating plan now offers a Dual-Eligible Special Needs Plan (DSNP) for its dual-eligible members. Beginning in 2027, all Medi-Cal managed care plans across the state are expected to offer DSNPs within their service areas. If you are dual eligible, you can change plans starting in January each year and can make changes every month thereafter.
3. **For a patient who has both Medicare and Medi-Cal, is one payer more likely to pay more than the other, or does this vary?** It varies. Due to complex regulations such as Prop 35, it can be challenging to determine which payer is the best. As a provider, you cannot choose which payer to use. Medi-Cal is always the payer of last resort. In most cases, Medicare will be the primary payer for individuals with both Medicare and Medi-Cal, with Medi-Cal covering the remaining costs as the secondary payer.

Dental

1. **Does Medicare cover any dental services?** No, Medicare does not cover dental services. During the last election campaign, there was a proposal to include dental coverage in both Medi-Cal and Medicare. However, in 1965, dentists were opposed to the idea of federal involvement in care, so dental services were excluded from the programs. Dental coverage can be a supplemental benefit. Many Medicare Advantage plans offer dental coverage as a supplemental benefit. Dual-eligible individuals receive dental care through Denti-Cal.

2. **Does Denti-Cal have authorization turnaround times like medical services?** While I am not entirely certain, I believe that timely access standards are included in Denti-Cal's contract, although it operates as a fee-for-service benefit.

Costs/Payments/Reimbursements/Spending

1. **What percentage of Medi-Cal spending goes toward nursing home care?** Nationally, Medicaid spends approximately $200 billion. While the specific number for California is unclear, it's reasonable to assume that California's share is around 10% of that amount.

2. **I read a policy factsheet today stating that a block grant proposal from the Trump administration would jeopardize access to Medi-Cal for one-third of Californians—more than 14 million people. Is there a precedent for such cuts to Medi-Cal? Do you think it's likely to happen?** I can't speculate on what might happen, sorry.

3. **Is the share of cost monthly or yearly?** The share of cost is monthly. Nursing facility residents are the primary enrollees with a share of cost, which they pay at the beginning of each month to cover the cost of their residence.

4. **Do you believe there will ever be a hybrid payment model for nursing homes or SNFs, where Medi-Cal, supplemental insurance, or private pay can be combined to cover services?** Medicare is part of the mix. It pays for nursing facility services when rehab is involved, provided that the patient receives at least three hours of rehab a day. Medicare monitors this weekly to ensure it's appropriate. When Medicare is involved, the payment amounts can vary, but the services provided are consistent across the country. This consistency makes it difficult to integrate other payers into the program.

5. **Why is there a Medicare premium? How can we get rid of that cost?** The Medicare payment structure was designed to ensure that enrollees had "skin in the game." Since the Medicare trust fund carries risk, it is unlikely that anyone is considering eliminating the enrollees' share. More likely, the cost for higher-income individuals will continue to increase.

6. **This seems to be coming up more frequently as non-traditional health providers (social service providers) enter into relationships with care plans. How do these "new" healthcare providers enter Medi-Cal to receive reimbursement for their services under CalAIM contracts?** Community-Based Organizations (CBOs) face challenges in entering contracts with health plans. Health plan contracts are clinically oriented, approved by DHCS, and often difficult for CBOs to comply with. To address this, several organizations have created hubs for CBOs to join. These hubs contract with health plans and then subcontract with CBOs to provide administrative services, such as claims submission.

7. **Aren't there restrictions on covering housing under Medicaid?** Housing services can include assistance in finding housing, paying for first and last month's rent, covering utility deposits, and providing social support to maintain housing. The new Transitional Rent benefit under BH-Connect offers six months of rent for individuals with behavioral health issues who are transitioning from various settings, including carceral environments or homelessness.

8. **How do you foresee services for people with disabilities changing if Medi-Cal providers transitioning to the Managed Care Program are limited by budget constraints?** I don't believe DHCS is currently considering transitioning Medi-Cal waiver services into managed care.

9. **According to news articles, California may be facing a $45+ billion deficit this year. Will this affect Medi-Cal next year?** Prop 35 has set rates for some providers but given that Medi-Cal is such a large part of the state budget, I believe reductions in other areas are inevitable.

10. **Do you believe there will ever be a hybrid payment model for elderly care in nursing homes or SNFs, where Medi-Cal, supplemental insurance, or private pay, can be used together to cover services? Currently, it seems to be either one or the other.** Medicare is involved in this process. It covers rehab services, but once a person's ability to progress in rehab ends, Medi-Cal takes over the payment responsibility. Medicare closely monitors progress in SNFs and will deny payment if no progress is evident.

11. **Do plans get paid well to take care of hard-to-serve populations? Is this an incentive to take on these populations?** Plans are paid a capitation rate for various groups, such as children, childless adults, and individuals with disabilities. However, plans' incentives to care for hard-to-serve populations are driven more by quality and access standards than by capitation payments. DHCS has begun sanctioning plans for poor performance in several areas.

12. **The rates that managed care plans pay to providers are confidential, but I understand that the state can set a floor for provider rates (e.g., for nursing home daily rates). Is this correct?** Yes, the state cannot pay less than the published Medi-Cal Fee-For-Service (FFS) rates. For certain services, such as nursing facility care, these rates are set, and they are almost considered a pass-through rate.

13. **With the Trump administration planning to cancel the GPP, what strategies should public hospitals leverage to make up for this financial gap?** I don't want to speculate about what the new administration might do.

14. **Since we have been paying into Medicare, if it "goes away," is there a way to get our money back to cover healthcare costs?** It's hard to imagine Medicare "going away," but it will likely be restructured. This may result in higher out-of-pocket costs for enrollees. The concept of privatizing Medicare, such as requiring all enrollees to join a Medicare Advantage plan, has also been discussed.

Medi-Cal 101 Webinar – Question & Answers

December 4 & 10, 2024

Waivers

1. **What does "waiver" mean? Where does the Assisted Living Waiver sit?** The Assisted Living Waiver is one of the home and community-based service waivers. It provides additional support to individuals living in Residential Care Facilities for the Elderly (RCFEs) or assisted living environments to help them avoid moving into a nursing facility. This waiver offers medical and other necessary supports, enabling individuals to remain in a less expensive, less institutionalized setting rather than transitioning into a more intensive medical facility.

2. Waivers are requests submitted to the Centers for Medicare & Medicaid Services (CMS) to waive certain federal regulations. They allow states to experiment with new approaches to providing services, or to restrict services to specific populations or geographic locations. If a state wants to offer different benefits or deliver them in an alternative way, it must seek approval from the federal government. This is important because at least 50% of funding is provided by the federal government. There are various types of waivers, such as 1115, 1915(b), 1915(c), etc.

   Through a waiver, the state is informing the federal government that it will deliver services in a way that differs from the traditional Medi-Cal rules and regulations. By doing so, the state is requesting permission and federal funding to implement these changes.

3. **When do California's existing Medicaid waivers expire? Is the state working on State Plan updates?** The state is continuously working on State Plan updates. However, the current waivers are set to expire at the end of 2026 and the end of 2029.

4. **Is the Waiver more available in the OC area, there is a lot of that in LA?** Sorry, I don't understand the question.

Pharmacy

1. **What is the difference between Medi-Cal Rx and CalRx?** Medi-Cal Rx is the Medi-Cal Pharmacy benefit, which covers prescription medications for Medi-Cal beneficiaries. CalRx is designed to reduce drug costs for specific drugs or populations outside of Medi-Cal. It focuses on cost-reduction strategies for certain medications, often targeting broader populations or specific groups beyond Medi-Cal recipients.

2. **Why were pharmacy benefits carved out to Medi-Cal Rx, and why the switch to Fee-For-Service (FFS) to cover these benefits?** The administration believed that it could save a significant amount of money by managing the pharmacy benefit statewide. By moving to a Fee-For-Service (FFS) model, they aimed to streamline the process, improve oversight, and leverage bulk purchasing to achieve cost savings.

Medi-Cal 101 Webinar – Question & Answers

December 4 & 10, 2024

Maternal Health

1. **In the context of Medi-Cal maternal health, a doula agency would need a business license. Our company, Expect, provides physician-approved fitness services for pregnant and postnatal individuals. How could we be covered through Medi-Cal, as we focus on wellness and maternity to help prevent maternal complications?** You could approach health plans to explore the possibility of including your services as part of their efforts to improve maternal health and birth outcomes. By presenting your services to support pregnant and postnatal individuals in preventing complications, you may be able to partner with health plans that are focused on improving overall maternal health outcomes. Additionally, you may want to explore opportunities to collaborate with Medi-Cal managed care plans, which often have a broader scope of services and may consider wellness programs that support maternal health.

Specialty Mental Health

1. **In smaller counties where the mental health plan only has one contracted provider, if an individual isn't happy with that provider, what would their options be, and whose responsibility is it to coordinate services?** The individual can file a grievance and may request a state fair hearing to be allowed to find another provider. The responsibility for coordinating services generally falls on the mental health plan, but the grievance process may help facilitate access to a different provider.

2. **Please clarify, is mild- to mod- a county responsibility and severe is the M/C Managed care responsibility?** It is the reverse: Counties are responsible for severe mental health diagnoses, while Medi-Cal Managed Care plans are responsible for mild to moderate conditions. The services covered for mild to moderate conditions include psychological services, lab services, testing, counseling, and medication management by psychiatrists.

3. **With the introduction of CalAIM and the new contract, county mental health programs and all Medi-Cal managed care plans are required to sign an MOU addressing coordination of care, cooperation, and collaboration. Given the already heavy workload of county mental health programs, this presents a significant challenge.** In our judgment, we wanted to ensure that individuals continued to have access to the counseling benefits they previously received. However, we could not require the managed care plans to provide coverage for serious mental illness in children, as this remains a county responsibility. Similarly, we could not mandate the counties to provide services for mild to moderate conditions, as this falls outside the scope of their contracts.

Medi-Cal 101 Webinar – Question & Answers

December 4 & 10, 2024

Health Plan Models

1. **Is the regional model like a flat rate, and is it in favor of the patient? Will there be transparency on these rates?** The regional model simply means that there are two health plans to choose from in the county. Health plan capitation rates are published on the DHCS website, but rates paid by the plans to providers are not made public.

2. **Is the two-plan model misleading, since more than one health plan can be available in a given area, essentially offering multiple plan options?** In 32 counties, Kaiser is an additional third option. However, to join Kaiser, a member must have a previous affiliation with the health plan.

3. **How do intercounty transfers work, considering that counties have different setup models (COHS, Two-Plan, Geographic Managed Care, etc.)?** When transitioning to a Two-Plan or GMC county, the member's eligibility will first be moved or reestablished in the new county. Then, they will go through the choice process to select a health plan.

4. **What's the difference between a COHS and a single plan?** Practically, there is no difference to the member.

5. **Which model provides the best quality of care for the most value, in your experience?** DHCS publishes an annual quality report that compares health plans. It is worth studying this report to understand which models perform best.

6. **Which model costs the least overall, while still maintaining high-quality service?** Costs vary by area, provider type, and member, so it's difficult to determine which model is the least expensive while ensuring high-quality service.

7. **Is the Sutter system of healthcare considered an LI (Local Initiative)?** No, Sutter is a network of providers—physicians, hospitals, and outpatient services—but not a Local Initiative (LI).

8. **Is there any interest in using data from the state's quality reviews to build a single statewide Medi-Cal managed care model based on the most effective regional model(s), as part of CalAIM's uniformity efforts? Or is the healthcare system too complex for that to work?** I don't think so. California has historically been focused on county control. Implementing a single statewide model could eliminate the county role, which might lead to a political fight that no one is willing to tackle.

Medi-Cal 101 Webinar – Question & Answers

December 4 & 10, 2024

Kaiser

1. **Could you expand on the Kaiser "affiliation" requirement before selecting Kaiser as a plan?** If you or a family member has been enrolled in Kaiser, it makes logical sense for the entire family to join the same plan. There is an affiliation or connection between you, your children, or other close family members when selecting Kaiser. This means that if you've been part of Kaiser in the past, it's easier to enroll or continue with the plan.

2. **At one point, a person's affiliation with Kaiser needed to fall within a certain period of time (e.g., within the last 10 years). Does Kaiser still have that time limit, or can the affiliation have occurred 25+ years ago?** I haven't seen a strict time limit; rationality is applied when considering past affiliations. However, there might be instances where Kaiser doesn't have records for individuals if too much time has passed. Overall, both the state and Kaiser are moving towards more open access to Kaiser as a plan option, but we haven't fully reached that point yet. Currently, Kaiser is carefully managing enrollment into Medi-Cal, with a more selective approach to contract negotiations and the number of people they are willing to accept into their Medi-Cal program. This represents a shift in both Kaiser's and the State's approach.

3. **Is this nuance with Kaiser why people who sign up for Kaiser Medi-Cal have difficulty getting substance use treatment?** Yes, Kaiser typically refers individuals needing substance use treatment to the County, which is responsible for these services. The state has included medication-assisted treatment (MAT) in the managed care plan contracts, which has caused some confusion over who is responsible for certain services. The counties have historically managed the social models of substance use treatment and residential care, while Kaiser focuses on medical aspects like detox and MAT. Detox and MAT are Kaiser's responsibility, but there's still some ambiguity and interpretation around this, which is ongoing.

4. **How is Santa Barbara able to keep Kaiser out? Is there a possibility for Kaiser to enter Santa Barbara County in the future?** From my perspective, it's not that Santa Barbara County is actively keeping Kaiser out; rather, Kaiser, as an independent non-profit organization, makes a marketing decision about which counties to enter. Kaiser typically finds employer groups interested in contracting, followed by medical groups willing to provide services. As these networks of employers and providers grow, Kaiser starts considering expansion into new areas, including Santa Barbara, based on demand and infrastructure.

5. **How is Kaiser able to participate in counties with COHS plans**? Previously, Kaiser subcontracted with County Organized Health Systems (COHS) and received membership through these plans. Today, Kaiser directly informs the county about their Medi-Cal members and indicates which individuals are now eligible for Kaiser services.

6. **When individuals go to Kaiser and are routed to "county" services, then "county" routes them back to Kaiser or declines services, how would these recipients navigate this complexity?** Kaiser's approach is not unique in navigating the relationships between county Behavioral Health (BH) programs and Medi-Cal managed care plans. This complexity is common and requires careful coordination between Kaiser and county services to ensure that individuals are properly connected to the right care.

7. **What is the difference between "Kaiser" and "Medical Kaiser"? Do both receive the same service?** Kaiser offers some unique services to its Medi-Cal members, such as Enhanced Care Management (ECM) or nursing facility care, which might not be available to other Kaiser members enrolled through employer-based plans. The services can differ based on the type of coverage the member has, as employer-based contracts with Kaiser may have different benefits compared to Medi-Cal plans.

Clarification

1. **Wasn't the first experiment in managed care in California under the Reagan administration in the 1970s?** I only have experience starting from 1983 in Managed Care. Before things were properly organized, there were some challenging and less successful periods with managed care in California.

2. **Could you briefly explain the difference between fee-for-service (FFS) and managed care plans?** In the Medi-Cal context, fee-for-service (FFS) was run by the Department of Health Care Services (DHCS). In this model, people would find a Medi-Cal provider, receive their service, and the provider would submit a claim to the state for payment. It was straightforward, with little oversight. With managed care, the state sends a set budget to a health plan. The plan contracts with providers to deliver care. Providers then submit their claims to the plan which is responsible for paying them.

   One advantage of managed care is that it allows the state to monitor various factors: who is receiving care, how quickly, where, and the quality of the care. This level of oversight is much harder to achieve in a fee-for-service model. In a fee-for-service program, the state had limited control over how care was delivered, making it challenging to ensure access, quality, and appropriateness of care.

3. **Can you talk more about the nursing home aspect of Medi-Cal? What makes it different from standard Medi-Cal?** In the past, nursing home care was handled by FFS Medi-Cal. Now, under managed care, health plans are responsible for nursing home care and must pay at least the rate established by DHCS.

4. **Could you please elaborate on what "carved out" and "carved in" mean in the context of Medi-Cal?** Carved out: This refers to services that are not provided by the managed care plan. Instead, they are handled by other organizations, such as a county, Medi-Cal Rx, or another entity. These services are paid for through a different mechanism.

Carved in: This means that the health plan is now responsible for providing and paying for the service. Under CalAIM, many services have been "carved in," such as organ transplants.

Carved out exceptions: Some services, like substance use disorders and serious mental illnesses, continue to be carved out of managed care and are still handled separately.

5. **Is the Transitional Rent Program being proposed just for California, or for the entire nation?** The Transitional Rent Program is proposed only for California.

6. **How often do FQHCs work with or submit claims to DHCS? Is there a process behind this?** Federally Qualified Health Centers (FQHCs) contract with Medi-Cal managed care plans and receive the same rate as other providers for similar services. However, as FQHCs, they are eligible to draw down additional federal funding. FQHCs submit this to the Audits and Investigation Division at DHCS, where the audit is performed to justify the funds drawn from the federal government.

7. **A couple of requirements: FQHCs can claim the PPS rate for only one service a day and within four walls. Can you provide some insight on how DHCS is going to provide access for people affected by SB-43 (drug users being determined gravely disabled)?** FQHCs can only claim the Prospective Payment System (PPS) rate for one service per day and within their facility. As for SB-43, which deals with people who are gravely disabled due to drug use, DHCS will likely need to ensure that access to services for these individuals is not restricted. Specific details will likely depend on the ongoing implementation of SB-43.

8. **You mentioned specific diseases like cancer and renal disease are covered through SNPs. Does something like HIV/AIDS have a similar program?** As of now, there are no HIV-specific Special Needs Plans (SNPs) in California. However, there is the AIDS Healthcare Foundation Health Plan, which is a disease-specific plan catering to individuals living with HIV/AIDS.

<u>Future Changes</u>

1. **Having seen all the developments in your career, what would you like to see for new developments in Medicaid and Medicare?** I would like to see fully integrated plans that encompass behavioral health, substance use disorders, dental care, and nursing facility care—basically, all the services a person needs in an easy-to-access, unified package.

2. **Can you share more about the current progress and/or challenges in California with the transition to MLTSS? I know California was exploring a state-funded option for long-term care (LTC), do you know the status on that?** The state is still working on that. There have been some incremental changes in moving nursing facility care under plan responsibility. Additionally, California is examining how to incorporate some of the waiver programs into plan responsibilities, though the Multi-Service Senior

Program (MSSP) still operates outside of managed care plans. Hopefully, CalAIM and some of the other programs will supplement and align with what MSSP provides. Over time, there is an effort to consolidate these services for a more streamlined system.

Links Shared in the Chat

1) Here are the 2024 FPLs: https://www.dhcs.ca.gov/services/medi-cal/eligibility/letters/Documents/24-02.pdf
2) Updated FPL chart: https://www.coveredca.com/pdfs/FPL-chart.pdf
3) National Committee for Quality Assurance https://www.ncqa.org/
4) Enhanced Care Management: https://www.dhcs.ca.gov/CalAIM/ECM/Pages/Home.aspx